Final Statement of Reasons
R-1-01

Title 10, Chapter 5.5

Sections Amended: 2698.200, 2698.201, 2698.301, and 2698.302

Insurance Code Section 12700, et seq., established the Major Risk Medical Insurance Program (MRMIP) in 1991, under the direction of the Managed Risk Medical Insurance Board (MRMIB). The program provides access to health insurance for individuals who are denied coverage, or offered excessive premiums due to pre-existing medical conditions. MRMIP subscribers can select from several health insurers or health maintenance organizations that contract with the Board. Subscribers pay monthly premiums that are currently from 25% to 35.7% more than what a healthy person in a similar plan would pay. The State subsidizes the remainder of the cost for health services with funding from the Proposition 99 Cigarette and Tobacco Products Surtax Fund. This is a capped appropriation, currently $40,000,000 per fiscal year and the Board limits enrollment in the program, through a waiver list, in order to stay within the capped appropriation. Since the program's inception, changes in the Health and Safety Code and the California Code of Regulations have changed the standard of benefits that are provided by the individual insurance market. The Board is committed to providing to MRMIP subscribers a comprehensive benefit package that is consistent with minimum State requirements for benefits under the Knox-Keene Health Care Services Act of 1975 and its amendments. To this end, and to be fully consistent with health plan regulatory requirements, the Board is making several revisions to the Minimum Scope of Benefits. Additional changes are being made to the Eligibility, Application and Enrollment sections to target access to MRMIP for persons in the individual insurance market, now that insurance reforms protect access in the small group market. The changes are as follows:

I. Section 2698.301 Minimum Scope of Benefits

Several Subsections of Section 2698.301 are amended so that benefits offered through MRMIP are more consistent with benefits provided in the individual insurance market. Although MRMIB has the authority to establish benefits for MRMIP, pursuant to Insurance Code Section 12711(b), MRMIB has always intended to provide a benefits package through MRMIP that is consistent with current individual insurance product offerings and with benefits that are required of health plans licensed under the Knox-Keene Health Care Service Plan Act of 1975, including its amendments (Health and Safety Code Sections 1367-1374.16). The Subsections of Section 2698.301 that are amended are as follows:

A. Subsection 2698.301(a), Minimum Scope of Benefits, is amended to require health plans offering benefits to MRMIP subscribers and enrolled dependants

to comply with the Knox-Keene Health Care Act of 1975, including its amendments, and applicable regulations.

B. Subsection 2698.301(a) (1) is a listing of hospital inpatient benefits for the program.

Subsections 2698.301(a)(1)(E), (F), (G), (H), and (I) are amended so that hospital inpatient care benefits are more consistent with the requirements of California Code of Regulations, Title 28 Subsection 1300.67(b). Physical therapy is added to Subsection 2698.301(a)(1)(E). Diagnostic laboratory and x-ray services is added to Subsection 2698.301(a)(1)(F). Special duty nursing, as medically necessary, is added to Subsection 2698.301(a)(1)(G). Administration of blood and blood products is added to Subsection 2698.301(a)(1)(H). Other diagnostic, therapeutic or rehabilitative services including occupational and speech therapy, as medically necessary, is added to Subsection 2698.301(a)(1)(I).

Also, to be consistent with Health and Safety Code Section 1367.2, medically necessary alcohol and substance abuse detoxification services are added to Subsection 2698.301(a)(1)(J). General anesthesia and associated facility charges in connection with dental procedures rendered in a hospital for specific subscribers are added to Subsection 2698.301(a)(1)(K), to be consistent Health and Safety Code Section 1367.71,

Through the 15-Day Re-notice process, Subdivision 2698.301(a)(1)(I) is revised to add "physical therapy" as these benefits were to be moved from subdivision 2698.301(a)(9) when occupational and speech therapy was incorporated into subdivision 2698.301(a)(1).

C. Subsection 2698.301(a)(2) is a listing of medical and surgical benefits for the program.

In order to be consistent with Health and Safety Code Section 1345, and to consolidate the services that are covered under physician services, Subsection 2698.301(a)(2)(A), Subsection 2698.301(a)(2)(E), and Subsection 2698.301(a)(2)(H) are stricken in their entirety and moved to the new Subsection 2698.301(a)(2)(A). Benefits listed in the new Subsection 2698.301(a)(2)(A) are: physician services, including consultations, referrals, office and hospital visits and surgical services performed by a physician and surgeon.

In order to be consistent with California Code of Regulations, Title 28 Section 1300.67(d), Subsection 2698.301(a)(2)(B) is stricken and replaced with new language. The new Subsection 2698.301(a)(2)(B) specifically

clarifies the inclusion of the following benefits: ultrasound, electrocardiography and electroencephalography.

Because the benefits listed in Subsection 2698.301(a)(2)(E) is moved to Subsection 2698.301(a)(2)(A), the former Subsection 2698.301(a)(2)(F), is now Subsection 2698.301(a)(2)(E), and the former Subsection 2698.301(a)(2)(G), is now Subsection 2698.301(a)(2)(F).

In order to be consistent with Health and Safety Code Section 1367.35, Subsection 2698.301(a)(2)(F) is stricken and is replaced with new language. The new language specifies that comprehensive care for children under the age of 16 is to be consistent with the Recommendations for Preventive Pediatric Health Care as adopted by the American Academy of Pediatrics in September of 1987, and the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

The benefits listed in Subsection 2698.301(a)(2)(H) is moved to Subsection 2698.301(a)(2)(A).

The new Subsection 2698.301(a)(2)(G) outlines anesthesia benefits that are to be provided for dental services in the outpatient setting. The benefits are added to be consistent with Health and Safety Code Section 1367.71.

The benefit listed in Subsection 2698.301(a)(2)(I) is moved to Subsection 2698.301(a)(3). Because the former Subsection 2698.301(a)(2)(I) is moved, Subsection 2698.301(a)(2)(J), is now Subsection 2698.301(a)(2)(H).

D. Subsection 2698.301(a)(3) is a listing of family planning services benefits for the program.

In order to be more consistent with the California Code of Regulations, Title 28 Section 1300.67(f)(2), family planning services that include a variety of prescription contraceptive methods approved by the federal Food and Drug Administration, are added to the program.

E. Subsection 2698.301(a)(3), which is a listing of maternity and perinatal care benefits for the program, is renumbered and is now Subsection 2698.301(a)(4).

In order to be more consistent with Health and Safety Code Section 1373.4, the services related to complications of pregnancy are added benefits to the program.

F. Subsection 2698.301(a)(4), which is a description of Emergency Care services, is renumbered and is now Subsection 2698.301(a)(5).

In order to be more consistent with Health and Safety Code Sections 1345 and 1371.5, the following benefits are added: out-of-area coverage and transportation provided through the "911" emergency response system.

G. Subsection 2698.301(a)(5), which is a listing of reconstructive surgery benefits of the program, is removed and replaced by Subsection 2698.301(a)(6).

Subsection 2698.301(a)(6) clarifies the reconstruction surgery benefit and is consistent with Health and Safety Code Sections 1367.6, 1367.63, and 1367.635.

H. Subsection 2698.301(a)(6), which is a listing of prescription drug benefits of the program, is renumbered and is now Subsection 2698.301(a)(7).

In order to be more consistent with Health and Safety Code Section 1367.51, the following benefits are added to the program: insulin, glucagon, syringes and needles and pen delivery systems for administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes.

I. Subsection 2698.301(a)(7), which is a listing of mental health benefits for the program, is renumbered and is now Subsection 2698.301(a)(8).

To be more consistent with Health and Safety Code Section 1374.72, the regulations have been amended to make clear that treatment for persons with certain mental health conditions are no longer limited to 10 days for inpatient care and 15 outpatient visits per calendar year. These severe conditions include serious emotional disturbances of children and severe mental illnesses, including: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Due to the addition of new Subsection 2698.301(a)(8)(A) and (B), former Subsection 2698.301(a)(8)(A) and (B), are now Subsections 2698.301(a)(8)(B)(1) and (2).

J. Subsection 2698.301(a)(8), which is a listing of medical rehabilitation benefits of the program, is renumbered and is now Subsection 2698.301(a)(9).

For greater clarity, the inpatient rehabilitation benefit is stricken from Subsection 2698.301(a)(9) and is added to inpatient benefits found in Subsection 2698.301(a)(1)(E) and Subsection 2698.301(a)(1)(I).

K. Subsection 2698.301(a)(9), which is a listing of durable medical equipment benefits for the program, is renumbered and is now Subsection 2698.301(a)(10).

In order to be more consistent with Health and Safety Code Sections 1374.51, 1367.6, 1367.63, 1367.635, the following benefits are added: prosthetics to restore and achieve symmetry incident to a mastectomy and to restore a method of speaking incident to a laryngectomy. Covered services include: blood glucose monitors and blood glucose monitors for the visually impaired for insulin dependent, non-insulin dependent and gestational diabetes; insulin pumps and all related necessary supplies; visual aids to assist the visually impaired with proper dosing of insulin and podiatric devices to prevent or treat diabetes.

Through the 15-Day Re-Notice process, Subdivision 2698.301(a)(9) is revised so that the wording is parallel to California Code of Regulations Title 28 Section 1300.67(c). The term "as appropriate" is added and the term "for short term therapy of acute conditions" is deleted.

L. Subsection 2698.301(a)(11) is a new subsection listing home health service benefits of the plan.

In order to be more consistent with Health and Safety Code Sections 1345 and the California Code of Regulations, Title 28, Section 1300.67(e), the following benefits are added: health services provided at the home care personnel including visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; short term physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Through the 15-Day Re-Notice process, the word "short-term" is removed so that home health services and exclusions are more consistent with California Code of Regulations Title 28, Section 1300.67(c).

M. Subsection 2698.301(a)(10), which is a listing of human organ transplant limitations, is renumbered and is now Subsection 2698.301(a)(12).

N. A new Subsection 2698.301(a)(13) specifies hospice benefits of the program and is added to be consistent with Health and Safety Code Section 1368.2.

O. Subsection 2698.301(a)(11) is renumbered and is now Subsection 2698.301(a)(14).

II. Section 2698.302 Excluded Benefits

A. Subsection 2698.302(a)(1) is changed to correct grammatical error.

B. Subsection 2698.302(a)(8) is changed so that the reference to Subsection 2698.301(a)(5)(C) (now Subsection 2698.301(a)(6)) is consistent with the new numbering structure.

C. Subsection 2698.302(a)(9) is changed to be consistent with benefits added in Subsection 2698.301(a)(3).

D. Subsection 2698.302(a)(12) describes the exclusion of dental services and services for temporomandibular joint problems.

In order to be more consistent with Health and Safety Code Section 1367.68, this Subsection is amended to clarify that medically necessary surgical procedures, for any conditions directly affecting the upper and lower jawbone, or associated bone joints, are not excluded benefits for this program.

E. Subsection 2698.302(a)(13) excludes the treatment of chemical dependency.

This subsection is amended so that only treatment of chemical dependency not specified in Subsection 2698.301(a)(1)(J) is excluded.

F. Subdivision 2698.302(a)(14) excludes the treatment of obesity by medical and surgical means.

Through the 15-Day Re-Notice process, this subsection is deleted to be consistent with the requirement that health plans provide basic health care services (e.g., inpatient professional services, etc.) when medically necessary (California Code of Regulations Title 28 Section 1300.67).

G. Subsection 2698.302(a)(15 is renumbered to new (a)(14) as existing (a)(14) was repealed.

H. Subsection 2698.302(a)(16)excludes Conditions resulting from acts of war

Through the 15-Day Re-Notice process, this subsection is amended to be consistent with California Code of Regulations Title 28 Section 1300.67.05 and clarify that this exclusion only applies if the exclusion is approved by specific order of the Director of the Department of Managed Health Care.

I. Subsection 2698.302(b) - Language in Subsection 2698.302(b) is stricken because the dates listed for the start of the $75,000 annual benefit cap are no longer necessary.

J. Subsection 2698.302(c) - Language in Subsection 2698.302(c) is stricken because the dates listed for the start of the $750,000 lifetime benefit cap are no longer necessary.

III. Section 2698.200 Basis of Eligibility and Section 2698.201 Application

The Board is also taking this opportunity to make a correction to the Major Risk Program's eligibility standards to conform to statutory changes in the small group (small employer) market. Subsection 2698.200(b)(1)(A)4 established as an eligibility category being a member of a group of two or fewer that has been denied coverage. In 1993 the ability of small groups to access health insurance was substantially reformed (Chapter 1158 Statutes of 1992 or AB 1672). Under these reforms, small groups of between 5-50 employees were given guaranteed access to and guaranteed ability to renew for health insurance at costs regulated to be lower than costs in the Major Risk Program. Under the reforms the number defining small group was gradually lowered to groups between 2 and 50. During this time the Major Risk Program was offered to very small groups until they came under the protection of small group reform. Now that those groups from 2 through 50 have full access to affordable insurance, the Board can delete eligibility due to denial of small group coverage entirely. Therefore the Board is proposing to delete Subsections 200(b)(1)(A)4, and 2698.201 (e)(1)(H)4. (The requirement requires proof of rejection for small group coverage from the regulations.)This will focus the program on those trying to access the individual insurance market, which does not have the protections of the small group market. This is consistent with Health and Safety Code Section 1357(l) and Insurance Code Section 10700 (w), which now define small employers, as groups of 2 through 50 and Health and Safety Code Section1357.03 and Insurance Code Section 10705, which give small groups access protections. This is authorized under Insurance Code Section 12711(a), which allows the Board to set eligibility standards for the program.

OBJECTIONS OR RECOMMENDATIONS MADE REGARDING THE PROPOSED REGULATION(S).

Commentor 1: **Frank Lee, Government Relations Director, Contra Costa Health Services, Contra Costa Health Plan, Provider Affairs**

Comment: After further review of the proposed regulations, there is a concern regarding Section 2698.302(a)(11). The Board needs to clarify that Section 2698.302(a)(11) does not apply to "short-term" coverage for "home care, skilled nursing care, respite care, and hospice care" which are basic benefits under Knox-Keene and the minimum scope of benefits as provided in section 2698.301 et seq. In the alternative, the Board may decide to modify Section 2698.301(a)(11) to specify that "home health services" is for short-term, intermittent care. In similar revisions to the Healthy Families Regulations, the Board added a phrase that "the section does not exclude short-term skilled nursing care or hospice" as provided in the benefits sections. Perhaps the Board needs to modify the MRMIP exclusion the same way.

Response: MRMIB did not consider this comment as it was received after the close of the comment period.

Commentor 2: **Robert Reinhard**

Comment 2-A: Mr. Reinhard states that the Governor and the State Legislature are now involved in grave budget discussions to address severe statewide revenue shortfalls, and urges MRMIB to take any action possible to at least maintain the level of coverage provided in these regulations (at affordable rates) and to provide coverage for a greater number of Californians than have previously been covered.

Response 2-A: MRMIB shares the commentor's concerns about the state budget problems and the potential impact on MRMIB programs and can assure the commentor that MRMIB will do everything within it's legal authority to at least maintain the minimum level of coverage within the resources of the program.

Comment 2-B: Mr. Reinhard proposes a change to Section 2698.302(b) – excluded benefits. The regulation excludes benefits which exceed $75,000 in a calendar year. He request the regulation be amended to allow coverage for benefits that exceed an average of $75,000 over a period of 3 or perhaps five rolling calendar years. Allowing an appropriate short term averaging feature will allow a subscriber to address catastrophic expenses that may occur in one year if

expenses in another year fall below the limit. Mr. Reinhard believes the averaging feature should not place an undue burden on the availability of coverage.

Response 2-B: No change is made to the regulations. Insurance Code Section 12712(e) requires MRMIB to operate the program within its designated appropriation. With an annual capped appropriation of $40 million dollars, the MRMIB has developed a benefits package (including the $75,000 annual cap on benefits) that provides comprehensive health services for as many individuals as possible. An increase in the benefits cap would result in increased in costs for the program, which would result in the need to decrease the number of enrolled subscribers.

The Legislature is currently considering a proposal (Assembly Bill 1401, as amended on June 20, 2002) to establish a 4-year pilot program (from July 1, 2003 to July 1, 2007) which would require health plans to provide guaranteed issue coverage to individuals who were previously covered under the MRMIP for 36 consecutive months. The health plan would offer these individuals a benefit plan which is based on benefits offered through the MRMIP. The benefit design would have an annual benefit limit of at least $200,000 and a lifetime cap of at least $750,000. At the time this document was prepared, a hearing in the Senate Appropriations Committee on AB 1401 was scheduled for August 5, 2002. Individuals in jeopardy of reaching the current $75,000 annual benefit cap could be helped by this proposal if it becomes law.

Commentor 3: **Managed Risk medical Insurance Board – Benefits & Quality Monitoring**

Comment 3-A: The proposed subdivision 2698.301(a)(1)(I) reads:

"Other diagnostic, therapeutic or rehabilitative services (including occupational and speech therapy) as appropriate."

MRMIB staff proposes that subdivision 2698.301(a)(1)(I) be revised to add "physical therapy" as these benefits were to be moved from subdivision 2698.301(a)(9) when occupational and speech therapy was incorporated into subdivision 2698.301(a)(1). Subdivision 2698.301(a)(1)(I) should read as follow:

"Other diagnostic, therapeutic or rehabilitative services (including occupational, physical and speech therapy) as appropriate."

Response 3-A: The suggestion has been accepted and the regulations changed.

Comment 3-B: Proposed subdivision 2698.301(a)(9) reads:

"Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists for short-term therapy of acute conditions on an outpatient basis."

MRMIB staff proposes that subdivision 2698.301(a)(9) be revised so that the wording is parallel to California Code of Regulations Title 28 Section 1300.67(c). Subdivision 2698.301(a)(9) should read as follows:

"Medical rehabilitation and the services of occupational therapists, physical therapists, and speech therapists as appropriate ~~for short-term therapy of acute conditions~~ on an outpatient basis."

Response 3-B: The suggestion has been accepted and the regulations changed.

Comment 3-C: The proposed subdivision 2698.301(a)(11) reads:

"Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; short term physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure."

MRIMIB staff proposes that the word "short-term" should be removed so that home health services and exclusions are more consistent with California Code of Regulations Title 28 Section 1300.67(c). Subdivision 698.301(a)(11) should read as follows:

"Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; ~~short term~~ physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure."

Response 3-C: The suggestion has been accepted and the regulations changed.

Comment 3-D: Subdivision 2698.302(a)(14) reads:

"Treatment of obesity by medical and surgical means, except for treatment of morbid obesity. In no instance shall treatment for morbid obesity be provided primarily for cosmetic reasons."

MRIMIB staff proposes that subdivision 2698.302(a)(14) be deleted to be consistent with the requirement that health plans provide basic health care services (e.g., inpatient professional services, etc.) when medically necessary (California Code of Regulations Title 28 Section 1300.67)

Response 3-D: The suggestion has been accepted and the regulations changed.

Comment 3-E: Subdivision 2698.302(a)(16) reads:

"Conditions resulting from acts of war (declared or not)."

MRIMIB staff proposed that subdivision 2698.302(a)(16) be amended to be consistent with California Code of Regulations Title 28 Section 1300.67.05. This subdivision should be revised to clarify that this exclusion only applies to instances when a plan is unable to provide health care services because of acts of war, rather than excluding any medical condition that is the result of war.

Subdivision 2698.302(a)(16) should read as follows:
"Conditions resulting from acts of war (declared or not)~~.~~ <u>if the exclusion is approved by specific order of the Director of the Department of Managed Health Care.</u>"

Response 3-E: The suggestion has been accepted and the regulations changed.

DATA STUDIES AND REPORTS RELIED UPON

The Board relied upon the Knox-Keene Act as amended and its implementing regulations in developing the new benefits standards. The appropriate sections of the Knox-Keene Act and its implementing regulations are cited in the Initial and Final Statement of Reasons. In eliminating the eligibility criteria for very small groups, the Board relied on the small group reform standards in the Insurance and Health and Safety Codes, which are cited in the Initial and Final Statement of Reasons.

STATEMENTS OF IMPACT AND MANDATE

a. The Managed Risk Medical Insurance Board has determined that the regulations would not impose a mandate on local agencies or school districts, nor are there

any costs to which reimbursement is required by Part 7 (commencing with Section 175000) of Division 4 of the Government Code.

b. Statement of Alternatives Considered.

In accordance with Government Code Section 11346.5(a)(12), the Managed Risk Medical Insurance Board has determined that no alternative considered by the Board would be more effective in carrying out the purpose for which the regulations are proposed or would be as effective and less burdensome to affected private persons than the proposed regulations.

c. Statements of Impact on Local Agencies, Private Persons, Businesses and Small Businesses.

There are no non-discretionary costs or new costs to local agencies or school districts.

There is no impact on California housing costs.

The Board has considered the cost impact on representative private persons or businesses impacted by these regulations. The Major Risk Program is for private individuals and their families. The elimination of small groups of two as a program eligibility category does impact businesses with two employees, but these businesses now have full access to lower cost health insurance through small group reform, and any individuals impacted can still join MRMIP as individuals. There is a positive impact on private individuals, who will now be assured that program benefits are current and consistent with the benefits required in the individual insurance market.

d. Business Impact Assessment.

The Board has made a determination regarding the impact of these regulatory changes on California's businesses. There is no known significant statewide adverse economic impact directly affecting California businesses, including the ability of California businesses to compete with businesses in other states. The changes involve updating the benefit package for individuals and families in program, and focusing program eligibility on individuals and families, now that small businesses from 2 through 50 now have full access to health insurance. Therefore, these regulations will neither create new jobs or businesses nor eliminate existing jobs or businesses or affect the expansion of businesses currently doing business within California.

e. Update – Fiscal Impact on State Government

The changes made as a result of public comments received during the 15-Day Re-Notice Process make minor adjustments to the MRMIB benefit structure. Since these changes only reflect current Knox-Keene Act standards, which health plans already follow, the Board believes these changes will have no measurable impact on program costs. The changes will not result in any request to increase the program's $40,000,000 budget. There remains no federal funding in the program.

SMALL BUSINESS IMPACT

These regulation changes will impact small businesses. The elimination of small groups of two as an eligibility category does impact small businesses with two employees, but these businesses now have full access to lower cost health insurance because of small group reforms, and any individuals impacted can still join MRMIP as individuals.

AUTHORITIES AND REFERENCES

These regulations were established under the authority of Insurance Code Sections 12711 and 12712 and in reference to Insurance Code Sections 12711, 12728, 12728, and 12733.

INCORPORATION BY REFERENCE DOCUMENTS

No documents were incorporated by reference in these regulations.